

factors in the genesis of stress incontinence. These data also suggest that the degree of bladder neck movement is not enough to contribute significantly to nerve damage and that nerve disruption, if significant occurs through mechanisms.

¹ Int J of Colorectal surgery 1995; 10(2):107-11

² BJOG 105:1300-1307

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Title (type in CAPITAL LETTERS, leave one blank line before the text):

POSTPARTUM STRESS INCONTINENCE: A GENUINE SYMPTOM?

Aims of study: Postpartum incontinence is common with a reported incidence of up to 35%^{1,2}. However is not clear whether this reflects the true incidence of genuine stress incontinence as most data is based on self reporting of symptoms and is often retrospective and unvalidated by objective studies. The aetiology of postpartum incontinence is unclear and commonly stress incontinence is thought to be secondary to genuine stress incontinence secondary to pelvic floor trauma at vaginal delivery^{1,2,3}.

The aims of this study were to undertake an alternative analysis of our subjective and objective epidemiological data to analyse postpartum urinary symptoms and their relationship to the underlying urodynamic diagnosis.

Methods: 161 nulliparous women were assessed at 12 weeks postpartum. A urinary questionnaire was completed asking questions regarding urinary frequency, nocturia, hesitancy, dribbling, incomplete emptying, staining to void, urgency, urge incontinence and stress incontinence. All women then underwent subtracted cystometry in the sit and stand fill position. Exclusion criteria included a history of urinary tract infection, anatomical urinary tract abnormality, diabetes or neurological abnormalities. All definitions conform to the ICS classifications.

Results: The incidence of reported urgency, urge incontinence and stress incontinence were 14%, 5% and 19%, respectively. The incidence of genuine stress incontinence, detrusor instability and voiding disorder were 5%, 6.8%, and 3.1% respectively. Normal urodynamic findings were found in 85.1% of women.

Symptom analysis of these women compared to urodynamic findings is shown in Table 1.

The urodynamic findings in those who were asymptomatic were compared with those who reported stress incontinence, or irritative urinary symptoms (urgency and/or urge incontinence), and are shown in Table 2.

Stress incontinence was reported by all women with a urodynamic diagnosis of genuine stress incontinence but also by those who had detrusor instability. Irritative urinary symptoms were also as common in both groups.

In those women who had a vaginal delivery urgency, urge incontinence and stress incontinence were reported by 15%, 5% and 21% respectively and 10%, 3% and 13% respectively of those who had a caesarean section. The incidence of detrusor instability and genuine stress incontinence on urodynamics was 7% and 5% respectively in those who underwent a vaginal delivery, and 6% and 3% in those who underwent a caesarean section.

Table One. Urinary symptoms and urodynamic diagnosis

Urinary symptoms	Urodynamic diagnosis			
	Normal (n=136)	Genuine stress Incontinence (n=8)	Detrusor instability (n=12)	Voiding disorder (n=5)
Stress incontinence	15%	100%	17%	-
Urgency	12%	38%	33%	-
Urge incontinence	5%	13%	-	-
Nocturia	32%	38%	33%	40%
Frequency	26%	25%	25%	40%
Hesitancy	0.7%	-	-	-
Poor stream	0.7%	-	-	-
Incomplete emptying	5%	-	-	20%
Dribbling post voiding	1.4%	-	8%	20%

Table Two. Urodynamic findings of asymptomatic compared to symptomatic women.

Symptom	Urodynamic diagnosis			
	Normal (n=136)	Genuine stress incontinence (n=8)	Detrusor instability (n=12)	Voiding disorder (n=6)
Asymptomatic (n=117)	105	0	7	5
Stress incontinence (n=22)	15	5	1	1
Irritative symptoms (n=17)	11	0	3	3
Mixed symptoms (n=12)	6	3	1	2

Conclusions: This study has demonstrated that postpartum bladder dysfunction is common with up to 27% of women reporting either irritative symptoms or stress incontinence. However although the main reported symptom was stress incontinence in 19% of women, genuine stress incontinence was only confirmed by urodynamics in 5% of women. A similar proportion of women (6.8%) were noted to have detrusor instability.

Vaginal delivery has been implicated as a major risk factor for postpartum incontinence, however a high proportion of women who underwent a caesarean section reported symptoms and 9% were found to have either genuine stress incontinence or detrusor instability. We acknowledge the small numbers of positive urodynamic diagnosis in this study, especially in the caesarean section group, however the incidence of both detrusor instability and genuine stress incontinence was similar in both the vaginal delivery and caesarean section group. This may explain why caesarean section has not always been shown to be protective against reducing the risk of postpartum stress incontinence¹ as the aetiology of postpartum incontinence maybe detrusor instability rather than genuine stress incontinence. This data also questions the validity of epidemiological data in reporting that vaginal delivery results in stress incontinence and highlights that additional tests are required to assess the cause and true incidence of postpartum bladder dysfunction.

References

1. Br J Obstet Gynaecol 1996; 103, pp154-161.
2. Int J Gynecol Obstet 1981;19, 13-20.
3. Obstet Gynecol 1992;945-949.

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Title (type in CAPITAL LETTERS, leave one blank line before the text):

URINARY AND FECAL INCONTINENCE AFTER INSTRUMENTAL VAGINAL DELIVERY. A CASE-CONTROL STUDY

Aim of study:

To evaluate the incidence of symptoms of urinary and fecal incontinence in primiparous women after instrumental delivery using a ventouse compared to spontaneous vaginal delivery.

Methods:

All primiparous women were invited to return for a follow-up appointment 6 to 24 months after delivery. For each instrumental delivery a matching control was examined. Matching criteria included the weight of the baby, type of episiotomy (no episiotomy, midline, medio-lateral) and perineal tears. Participants completed a detailed questionnaire on symptoms of urinary and fecal incontinence including the frequency of symptoms and a visual analog score (VAS) to evaluate subjective severity. Women were asked to state if symptoms had started before pregnancy, during pregnancy and after delivery. Pelvic floor muscle strength was assessed using the Oxford grading (0= nil to 5=very strong). Endoanal ultrasound was performed to detect defects of the internal and external anal sphincter. All patients with symptoms were offered to join the pelvic-floor reeducation program.